Nashua School District
Food Allergy Medication Instruction

Student Name ______________________ DOB ______________________

School ______________________ Teacher ______________________

Allergy ______________________ Asthmatic: ☐ YES (Higher risk for severe reaction) ☐ NO

STEP 1 - TREATMENT			
Reaction Area	**Symptoms**	**Administer Checked Medication** *(Determined by physician authorizing treatment)*	
Food allergen ingested	*No symptoms*	☐ Epinephrine	☐ Antihistamine
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine	☐ Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine	☐ Antihistamine
Throat*	Tightening of throat, hoarseness, hacking cough	☐ Epinephrine	☐ Antihistamine
Lung*	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine	☐ Antihistamine
Heart*	Thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine	☐ Antihistamine
Other*		☐ Epinephrine	☐ Antihistamine
Several Areas Above Affected	Reaction progressing	☐ Epinephrine	☐ Antihistamine

*Potentially life-threatening. ***The severity of symptoms can quickly change.***

DOSAGE

Epinephrine: ☐ EpiPen® ☐ EpiPen® Jr. ☐ Twinject™ 0.3 mg ☐ Twinject™ 0.15 mg *Route:* Inject intramuscularly

Antihistamine: *Medication:* ______________ *Dosage:* ______________ *Route:* ______________

Other: *Medication:* ______________ *Dosage:* ______________ *Route:* ______________

STEP 2 - EMERGENCY CALLS				
1	**Call 911** (or Rescue Squad)	Telephone:	State that an allergic reaction has been treated and additional epinephrine may be needed.	
2	**Call Dr.**	Telephone:		
3	**Call Emergency Contacts:**			
	Name	***Relationship***	***Telephone 1***	***Telephone 2***
	a)			
	b)			
	c)			

AUTHORIZATION		
Parent/Guardian Signature	**Print Name**	**Date**
Doctor's Signature *(Required)*	**Print Name**	**Date**

Nashua School District

Medication Authorizing and Hold Harmless Agreement

Medication Authorizing and Hold Harmless Agreement
<u>Over-the-Counter</u> Medication

To the Nashua Board of Education:

We, the undersigned, are the parents/guardians of ________________________, who lives with us at ________________________ in Nashua, New Hampshire, and who attends ________________________ School in the Nashua School District.

We feel that our child may benefit from the following over-the-counter medication: ________________

Medication Authorizing and Hold Harmless Agreement
<u>Prescription</u> Medication

To the Nashua Board of Education:

We the undersigned are the parents/guardians of ____________________, enrolled in the Nashua School District, who lives with us at ________________________ in Nashua, New Hampshire. This child is a student at ________________________School and is under the care of Doctor ________________________ whose address is ______________________________. The Doctor has prescribed that this child be given ______________________________ in accordance with his/her written instructions, which are attached hereto, and we desire that the Nashua School District personnel give the child assistance in the taking of this medication. The medication is to be given at the following dates and times:

Dates	**Times**
________ (mm/yyyy) through ________ (mm/yyyy)	as needed ______________

We hereby agree to indemnify and hold forever harmless the City of Nashua, the Nashua Board of Education, and their respective officials, agents, servants and employees against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made to brought against loss from any and all claims, demands, or actions in law or in equity that may hereafter at any time be made or brought by said minor or by anyone on behalf of said minor for the purpose of enforcing a claim for damages on account of any injuries or loss sustained in consequence of the aforesaid assistance, and we do hereby waive any and all rights of exemption, both as to real and personal property, to which we may be entitled under the laws of this or any other state as against such claim for reimbursement of indemnity.

____ ________________________________

Signature of Parent/Guardian Date Phone #

NOTE: A WRITTEN STATEMENT MUST BE RECEIVED FROM THE LICENSED PRESCRIBER DETAILING THE METHOD OF TAKING THE MEDICATION, THE DOSAGE, AND THE TIME SCHEDULE TO BE OBSERVED. MEDICATION SHOULD BE DELIVERED TO THE SCHOOL BY THE PARENT/GUARDIAN AND MUST BE IN AN APPROPRIATE CONTAINER THAT IS PROPERLY MARKED BY THE PHARMACY OR MANUFACTURER. THE CHILD TO WHOM THIS PERMISSION APPLIES MUST STRICTLY FOLLOW THE INDIVIDUAL CARE PLAN WITH REGARDS TO SELF MEDICATION IN SCHOOL IN ACCORDANCE WITH THE STATE OF NEW HAMPSHIRE POLICES ON SELF MEDICATION.

SH/dn Nurses/Grants & Community Development 05/2011